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ABSTRACTS

VIDEO PRESENTATIONS

TOPIC 1 : ENDOMETRIOSIS / ONCOLOGY

V-01

Reconstructive Surgery for Ureteral Endometriosis

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Introduction: We have developed a new technique to manage stricture of the ureter due to deeply infiltrating endometriosis. Treatment of deep endometriosis and related severe fibrosis is often challenging, with even silent loss of renal function reported. In the most severe cases, segmental resection of organs and reconstructive surgery is required.
Methods: Since 2002 we have created a technique to manage ureteral injury or pathology to reduce operative morbidity. Initially we introduced laparoscopic ureteral reimplantation to deal with intraoperative ureteral injuries. We adapted this less invasive technique for ureteral endometriosis. 13 patients have undergone this technique-4 of these for ureteral stenosis or obstruction of the ureter due to endometriosis. In this video three of these cases will be presented. Case one presented with complete obstruction of the right lower ureter at the level of the uterine artery. Case two suffered from renal insufficiency due to bilateral severe stenosis. In case three a considerable length of the pelvic ureter had to be sacrificed to resolve extensive stenosis. The first two cases underwent segmental resection of the involved ureters and subsequent reconstruction with anti-reflux extravesical ureteroneocystostomy. After incising the detruser muscle of the bladder, the bladder mucosa is exposed. The caudal end of the mucosa is opened and the caudal end of the transected ureter is anastomosed to the mucosa after fixation with anchor suture. The detruser muscle is reapproximated over the ureter and bladder mucosa so as to make an anti-reflux mechanism. In case three we performed Boari's flap technique with a psoas hitch to extend the bladder to deal with the shortness of the ureter. We also present a new technique for placing a Double J stent under laparoscopic control without using cystoscopy.
Results: The postoperative course was uneventful and no cases experienced leakage from the anastomosic sites. After a mean observation period of 24 months (12–48 months), no cases experienced recurrence of endometriosis and in every case renal function was preserved, important issues for sufferers of this disease.
Discussion: Ureteral endometriosis is a debilitating disease which can be managed efficiently and effectively with these technique. Although demanding, mastering precise suturing techniques inside the body is vital for creating leak-free, stenosis-free and anti-reflux anastomosis.

V-02

Laparoscopy. A feasible approach to treatment of multi-organ endometriosis

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Objective: To demonstrate the feasibility and advantages of laparoscopic treatment of multi-organ, deep, infiltrating endometriosis.
Setting: Hautepierre University Hospital, Strasbourg, France
Subject: A patient with a rare combination of endometriosis involving reproductive system, gastro-intestinal tract, urinary system and thorax. The progress of treatment, complications and recovery were followed for 6 months.
Interventions: Laparoscopy performed by a multi-disciplinary team involving dissection of deep infiltrating endometriosis, sigmoid resection, bladder nodule resection and ileostomy, followed by a thoracoscopy with pleurectomy and a second-look laparoscopy.
Discussion: It is feasible, effective and advantageous to approach endometriosis with laparoscopy, particularly in multi-organ disease when all areas of the abdomen and pelvis can be accessed without the need for large surgical incisions. Surgeons benefit from magnification, local precision, ease of surgical exposure, optimal dissection techniques, and the ability to shape the information on the screen. Due to the severity of this lady's disease, the rare complication of post-operative fistula was highly likely. We were able to successfully manage her fistula conservatively with prolonged

ureteric stent and indwelling urinary catheter until the vaginal leak had stopped. It is vital to fully visualise the diaphragm in every case of severe endometriosis. This can easily be done via laparoscope. It is crucial to involve a multi-disciplinary team familiar with laparoscopic techniques and with experience in endometriosis.
Conclusion: Laparoscopy appears to be ideally suited to this type of multi-organ surgery and we look forward to future advances in this field.

V-03

Retroperitoneal anatomy: laparascopic lymphadenectomy

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Objective: The laparascopic approach is being widely recommended instead of traditional laparatomic surgical staging. For this reason, in order to understand retroperitoneal anatomy better, it is aimed to give a better education with the help of images recorded during lymphadenectomy with comparison on images from Netter anatomy atlas.
Method: In order to take a better image, a 10 mm sized trochar at umbilical level,2 5 mm sized suprapubic trochar, and another 10 mm sized trochar onto the place between imaging and suprapubic trochar on the left side were placed. After enough insufflation of CO2, pelvic paraaortic procedure is performed.
Results: In laparascopy compared with laparatomy, it is reported that there is less morbidity, hospital stay,and faster return to social daily activities (1). In 1992, after described in 2 cases,has been widely used in earlt stage endometrium cancers(2). In our clinic,the first pelvic-paraaortic lymphadenectomy was performed in an endometrium cancer case in 1992.
In endometrium cancer, laparascopic staging is a more acceptable approach (2). In 5 cases, for staging in advanced stage cervical cancer paraaortic, in 35 cases total lympha denectomy was performed. In 6 cases, total lymphadenectomy was performed as bilateral pelvic and paraaortic lymphadenectomy. Among these cases, 4 cases were ovarian tumours, 2 cases were diagnosed as endometrium cancers diagnosed postoperatively. In 29 cases LAVH was performed together with total lymphadenectomy. The conversion rate to laparatomy due to severe adhesions and inappropriate imaging is %8, the short term complication rate such as major vessel or ureter traumas is about %7. Among 40 cases, in 3 cases laparatomy, in 2 cases major vessel trauma has developed. Among 2 major vessel traumas, in one case injury of inferior vena cava was observed and in other case internal iliac vein was injured and was sutured after conversion to laparatomy.
By the help of selection of patient for laparascopic surgery and by having enough knowledge about the habitus of tumoural metastasis, the subcutaneous metastasis rate can be kept at %1, and this is similar to the rate of incision site metastasis in open surgery(3).
Conclusion: Laparascopic lymphadenectomy gives the patient the opportunity of decreased remission time and hospital stay.

V-04

Laparoscopic para-aortic lymphadenectomy: our experience

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Introduction: Para-aortic lymphadenctomy has been introduced about 15 years ago. In this paper we want to report about our experience in para-aortic lympadenectomy and some modified steps in the technique.
Materials and Methods: We reviewed the videos of 27 patients undgoing para-aortic lymphadenectomy as a bioptic procedure or as part of a larger intervention. Three patients had only right inframesenteric lymphadenectomy. Twelve patients had bilateral inframesenteric lymphadenectomy, and 12 an infrarenal procedure.
Indication to paraortic lymphadenectomy were ovarian restaging in 13 cases, preoperative staging of cervical cancer in 3, staging or restaging in endometrial cancer in 6. Six patients underwent paraortic lumphadenectomy in lymphoma. As a first step we incise the peritoneum on the right common iliac vein. Then we dissect on the aorta to the inferior mesenteric artery and we prepare the left inframesenteric space. Lymphadenectomy is performed from the right side of the patient and both operators stay on the same side. The right lymphadenectomy is perfomed subsequently standing on the left side of the patient. Bipolar coagulation was used to accomplish hemostasis.
Setting: University, tertiary referral center
Results: The median duration of the procedures was 97 minutes (range 45–180). The mean number of lymphnodes was 18 (range 5–40). The mean body mass index of the patients was 21,35 (19,05–30,21). Two patients had laparotomy: one to control a perforating vessel from the vena cava, and one because of technical difficulty in dissection of the lymphnodes. One lesion of the inferior mesenteric artery was controlled by laparoscopy.
Discussion: We believe that the advantages of laparoscopic para-aortic lymphadenectomy greatly overcome the traditional approach. However technically the procedure is difficult for all the team. Starting from the left side in our

hand is better because all the first part of the procedure need dissection of arterial vessels.

V-05

Laparoscopic Vascular Injury Repair In Retroperitoneal Lymphadenectomy

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Introduction: Although complete lymphadenectomy is possible laparoscopically, there is a risk of vascular injury as we have to work close to the major vessels in oncologic surgery. We have introduced an open vascular suturing technique into the laparoscopic environment creating a total endoscopic repair technique to avoid the conversion to laparotomy.
Methods: After establishing a training system using an animal model, we applied this vascular suturing technique to clinical cases. Of 356 cases, which underwent radical oncologic surgery including retroperitoneal dissection, 18 underwent intraoperative vascular repair applying intracorporeal suturing. Three of these cases will be presented. Case one suffered an avulsion injury of the IVC during a retroperitoneoscopic para-aortic dissection. Case two suffered deep pelvic bleeding due to the laceration of the posterior aspect of the external iliac vein during a laparoscopic pelvic lymphadenectomy. Case three suffered the accidental partial severing of the external iliac artery by monopolar cautery during a pelvic lymphadenectomy. Procedure: In all cases temporary bleeding control was achieved using various types of laparoscopic vascular clamps for temporary hemostasis as well as a fine slip of sponge or looped vascular tape to retract vessels and control bleeding. After these preparations, the following procedures were performed. Case one-retroperitoneoscopic suturing was performed to close the hole of the IVC. For Case two, a Z suture was applied to close the laceration in the deep pelvis laparoscopically. In Case 3 temporary bleeding control was achieved using vascular clamps and then the full layer interrupted suturing of the external iliac artery was performed.
Results: Intracorporeal suturing proved successful both laparoscopically and retroperitoneoscopically. All 18 cases were successfully managed intraoperatively without conversion. All the patients were able to ambulate and take a regular diet two days after surgery. No cases suffered from vascular stenosis or postoperative bleeding and no cases required a blood transfusion.
Discussion: For vascular surgery, maintaining a blood-free operative field is paramount to precise placement of the suture. Although technically demanding, mastering the techniques to control bleeding and performing precise suturing is vital for confronting situations where intraoperative repair is necessary to avoid a conversion to laparotomy. Preparation for unexpected scenarios makes endoscopic extensive vascular dissection safer, more complete and patient friendly.

V-06

TLRT (Total Laparoscopic Radical Trachelectomy)-With The Reanastomosis Of The Accidentally Injured Uterine Artery

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Introduction: Vaginal trachelectomy with type II radical parametrectomy has been well reported and although rare, recurrences were reported at the lateral parametrium. Our concerns with the inadequate resection of the parametrium and operability in narrow vaginal access cases led us to develop a Type III total laparoscopic counterpart focusing on the isolation and removal of the total length of the parametria.
Methods: 25 patients with stage 1a2 to stage 1b1 cervical cancer who underwent a total laparoscopic radical trachelectomy were analyzed retrospectively.
Procedures: First we create a vaginal cuff then begin the pelvic lymphadenectomy using our umbilical ligament suspension technique. After isolation and preservation of the uterine artery, the pararectal space is developed isolating the cardinal ligament. The cardinal ligament is then transected at the pelvic sidewall using a linear stapler. All other paracervical ligaments as well as the vagina are transected. Then the cervix and paracervix are resected. In the case presented, the main trunk of the uterine artery was accidentally sealed and transected. The uterine artery was reconstructed by reanastomosis using 3 mm micro-suturing instruments. After reconstruction, the vagina was anastomosed to the cervix.
Results: Average duration of the procedure was 5 hr 50 min and blood loss measured 485 mL. No complications occurred except for temporary lymphedema. Although one case with lymphatic space invasion died from recurrences at multiple sites, the other 24 cases are alive with no evidence of disease after 6 to 72 months. Only 5 cases have attempted pregnancy, of these 2 cases have become pregnant. One case, who terminated at 21 weeks due to PROM and intrauterine infection in the first pregnancy, is currently 8 weeks pregnant for the second time. The other case had a 1908g female healthy infant at 34 weeks by cesarean section.

Discussion: Type III radical transection of the cardinal ligament is possible totally laparoscopically preserving the uterine artery so even cases suffering from malignant disease can benefit from new procedures that improve the quality of life. However, manipulation of the uterine artery may lead to inadvertent injury of this vessel making knowledge of repair techniques essential.

TOPIC 2 : UTERINE PATHOLOGY

V-07

Dangerous development of pregnant noncommunicating rudimentary uterine horn presenting placenta percreta

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Objective: To report a placenta percreta in a 7 week-gestations rudimentary noncommunicating uterine horn pregnancy.
Design: Case report.
Patient: A 28-year-old nulliparous woman with no complaint at 7 week-gestations.
Intervention: Rudimentary uterine horn pregnancy suspected by ultrasonography and diagnosed by laparoscopy. Laparoscopic excision of the rudimentary uterine horn and ipsilateral salpingectomy were performed, as well as biopsy of several peritoneal endometriosis lesions.
Results: An 8 week-gestations pregnancy with placenta percreta was identified in the rudimentary uterine horn. No communication was found with the right unicornuate uterus. Endometriosis was confirmed. Clinical outcome was favorable.
Conclusion: Placenta percreta may occur in rudimentary uterine horn pregnancies, but accidents may be avoided by an early diagnosis and surgical management. However, in young women with pregnancy desire, the planned laparoscopic resection of a rudimentary uterine horn revealed accidentally could be discussed.

V-08

A one-step-laparoscopic myomectomy method for multiple leiomyomas- including submucosal fibroids.

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Objective: Leiomyomas are found in various areas including the submucosa. This method can be performed in one step for cases of multiple leiomyoma, without the need for transcervical resection (TCR), and is even appropriate for cases with submucosal myoma. I will introduce a laparoscopic method for the removal of submucosal myomas which doesn't require hysteroscopy.
Materials and Methods: Diluted vasopressin was injected into the subserosa of the uterus in order to reduce surface perfusion and prevent excessive bleeding. Then the uteruine wall is incised with monopolar pure cutting current in order to prevent thermal injury and to reach the correct dissection plane. We use a vertical incision instead of a transverse incision in order to be able to remove various size myomas in various locations within the uterus. In the removal of the submucosal myoma, the endometrial cavity was opened and it was removed using a fishing method and claw forceps. The endometrial cavity was filled with absorbable synthetic mesh to prevent adhesion and to maintain the uterine cavity. The defect of the uterus is closed in layers. The endometrial layer was closed by monofilament 4-0 continuous suture. The outermost surface layer, the seromuscular, was approximated with interrupted mattress sutures which prevents eversion of the wound and so helps prevent surface bleeding and adhesion. All of the fibroids removed in our procedure were retrieved through the cut opening in the posterior fornix of vagina.
Results: A vertical incision creates enough access to the deep pelvis to make the removal of submucosal fibroids, even in deep areas, easier totally laparoscopically. To prevent adhesion, absorbable synthetic mesh was placed into the uterus and the endometrium was repaired using monofilament suture. The postoperative course was good in our cases and no complications occurred. All of the patients bleeding symptoms were resolved postoperatively and the uterine cavity was adequately maintained in both cases.
Conclusions: Laparoscopic myomectomy for multiple myoma cases, including submucosal myoma, is possible in a one-step procedure. With our technique it is not necessary to perform a hand assist procedure via mini-laparotomy or TCR. This method is minimally invasive, time saving and low cost and can become a future standard for multiple myoma removal.

V-09

Technique of laparoscopic hysterectomy in virgo patient

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Objective: Laparoscopic hysterectomy (LH) was performed without uterine manipulator use to submit virgo patient.
Design & Methods: Six virgo patients occurred to the Department of Gynaecological Sciences and Human Reproduction of Padua University for total laparoscopic hysterectomy for benign pathologies between June 2006 and April 2007. The women were affected by fibromatuos uterus, four of them presented menorrhagia. The mean age of the patients was 54± 14.35 years, the BMI was 23.8±10.81; only one patient was treated with preoperatively GnRH analogues for two months. The operative time was 181±63.48 min, the uterine weight was 362±193.82 g, the intraoperatory blood loss was 44± 33.61 ml. No intraoperatory complications were seen. Only one patient presented fever >38°C after surgery. Fever, treated with antibiotic therapy, lasted for one day only. Histological examination confirmed uterine leiomyoma in all cases. The patients, discharged after 3±1.7 days from surgery, showed high satisfaction.
Results: The patients underwent to LH, without uterine manipulator use to respect the integrity of distal genital organs, as request. The procedure consists first in the round ligament coagulation and section, then in the opening of the lateral peritoneal layer of the broad ligament. After the visualization of the ureter in its pelvic part, the uterine artery is skeletonized, coagulated and dissected nearby its separation from hipogastric artery. Then the salpinx and the utero-ovarian ligament or the infundibolopelvic ligament are coagulated and transected. The incision of the vesico uterine fold follows bladder filling (200/300 ml). The cervical-bladder tissue is coagulated and dissected until the vagina. The utero sacral ligaments and upper part of the cardinal ligaments are coagulated and dissected. The vaginal wall is opened with a circular cut exactly where the surgeon perceives by a grasper the different tissue consistency between cervix and vagina. The uterus is removed by morcellement. The vaginal vault is sutured endoscopically by interrupted intracorporal sutures: one in the middle part, two in the lateral incorporating pubocervical fascia and uterosacral ligament stumps. All time periods of the procedure were made by bipolar energy.
Conclusions: Laparoscopic hysterectomy without uterine manipulator is possible but it is necessary an adequate knowledge of the anatomic reference marks.

V-10

Training model for a TLH (total laparoscopic hysterectomy)-smoothing away difficulties by understanding the difference between laparotomic and laparoscopic anatomy

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Objective: Difficulties arising in laparoscopic operations is well known to originate from the difference between laparotomic and laparoscopic anatomical images. To deal with the difficulties in the laparoscopic environment, we have devised an artificial anatomic model for training.
Design and Method: In this training model, the position of the artificial uterus can be changed by using a uterine manipulator. The artificial uterus, ureter and blood vessels are made of elastic rubber materials. The TLH procedure in our institution is as follows.Our first step is identification and isolation of the uterer in the retroperitoneal space. Then, after separation of the bladder off the cervix, transection of the parametrium follows. The vagina is transected with the aid of our vaginal pipe. The uterus is retrieved through the vagina. The final step is the closure of the vagina and then reapproximation of the pelvic peritoneum using intracorporeal suturing In the laparoscopic environment, there always possibility of causing organ injuries due to lack of depth perception and/or spatial disorientation. Our technique is characterized by initial isolation of the course of ureter by dividing the uterine artery to avoid ureteral injury during the following step of parametrial dissection. After thorough identification of anatomical structures, we can perform TLH safely even in severely anatomically distorted cases. However difficulty for beginners in this operation is rooting out the ureter and uterine artery. We must comprehend the three dimensional relationship of the uterine artery, diverging from the internal iliac artery and ureter. By introducing this model into training, we can comprehend the pelvic anatomy, especially the three dimensional relationship between the uterus, ureter and important blood vessels.
Results: TLH could be performed smoothly and safety after comprehending anatomy under laparoscopic vision by introducing our model into the training program.
Conclusion: It is important to comprehend anatomical relationships, as well as improving surgical skills to decrease complications.However, it is very difficult to establish three dimensional spatial orientation from the two dimensional image in the laparoscopic surgery environment. As the opportunity in real clinical experience is limited, our model for simulation is useful to help understand the difference of anatomic images in the laparotomy and laparoscopy environments.

V-11

A new technıque ın laparascopıc hysterectomy: laparascopıc hysterectomy performed through one ancıllary trocar

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Objective: Here is presented as to demonstrate the least invasive technique of minimal invasive surgical procedures.
Laparascopic Hysterectomy Method: The incidence of endoscopic hysterectomies has increased to %54 from %18 (1). There are several laparascopic radical hysterectomy methods such as open laparascopy, SECURE cone, and robotic assisted methods (2,3,4,5,6). When laparascopic ,vaginal and abdominal hysterectomies are compared, in laparascopic hysterectomy, the complication rate ,bleeding and postoperative pain and hospital stay were all found low (7,8,9).
Technique: Patient was positioned in lithotomy. Verres needle was inserted to abdomen and after insufflation of appropriate amount of CO2, skin below umbilicus was incised by 1 cm in order to protrude 10 mm sized trochar so as to insert optic instrument.Later on, a 0.5 cm sized second incision was performed onto skin just superior to pubic hair under route of umbilical line. From this incision,a 5 mm sized trochar was inserted. As secondary assistance, via vaginal route by manuel touche, uterine manipulation was achieved. Uterus was positioned in anteversion by vaginal touche, and bilateral round ligaments were cut by endoshears by the help of monopolar coter. Later on, uterus was pushed to right laterally by vaginal touche and left suspensory ligament of the ovary became visible and was sutured intracorporally by 1 no sized chromic catgut. The needled part of the suture located outside is rotated by 180 degree and the needle is passed between the formed hole and tracted and the suture is ligated. The suture is tied for 3 times. Bilateral suspansory ligaments of ovaries and uterine arteries are ligated by the same technique. Before any access to uterine arteries, bladder was seperated from uterus by the help of endoshears. Then , operation is completed by vaginal procedure. Laparascopic hysterectomy was performed in such a way.
Results: The lowest number of trochar site (2 in total) is important for the integrity of tissues, and the minimalisation of pain. In these operations, 50 mg of contramal is used by PCA system for analgesia. It may be hopeful for future. The operation time is 1 hour and 35 minutes.
Conclusion: This is a new technique, and it is probable that new modifications can be performed in future. It may be more convenient to evaluate this condition in more appropriate situations.

TOPIC 3 : MISCELLANEOUS

V-12

Dysmenorrhoea Leading To An Acute Abdomen: Three Case Reports Of Urogenital Malformations

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Introduction: About 1% of all females suffer from urogenital malformations. Symptoms are mainly unspecific and can result in acute abdominal pain as in appendicitis, painful periods or micturition disorders. In these cases, urogenital malformations should be considered in order not to postpone diagnosis and to lead to an adequate therapy preventing further complications.
We present three typical cases of urogenital malformations using a video.
Methods: Case 1: A 24-year-old women with increasing painful periods is being hysteroscoped with a submucosal fibroid being suspected. Laparoscopy confirms a unicorn uterus with a rudimentary right horn and hematometra. The rudimentary horn is being removed.
Case 2: A 14-year-old adolescent is being laparoscoped because of increasing painful periods and a suspicion of acute appendicitis. Intraoperatively, a bicornate uterus with a non-communicating right horn and hematometra is found and the right horn is removed.
Case 3: In a 14-year old with secondary amenorrhea and increasing abdominal pain hysteroscopy and laparoscopy was performing confirming a uterus and vagina duplex with an atretic cave on the right side resulting in a right-sided hematocolpos with hematometra which were drained by a vaginal incision. Postoperative ultrasound demonstrated a missing kidney on the right side.
Results: Laparoscopic removal of atretic uterus horns can be performed laparoscopically by a skilled surgeon. Drainage of hematokolpos and atretic one-sided vagina is also easily feasible. All patients recovered easily postoperatively.
Discussion: Genital malformations must be considered into the differential diagnosis of painful periods and acute abdominal pain. Additional malformations of the upper abdominal tract must be looked for.

V-13

Laparoscopic Bilateral Gonadectomy for Pure Gonadal Dysgenesis (Swyer's Syndrome)

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Pure gonadal dysgenesis is characterized by a female phenotype with an XY karyotype, a palpable müllerian system, normal female testosterone levels and lack of sexual development. There are fibrous bands in place of the gonads, yielding primary amenorrhea and immature secondary

sexual characteristics. In order to avoid the possibility of malignant transformation, removal of these streak gonads is advocated as soon as the diagnosis is made.
The authors present the surgery of a 16-year-old female with primary amenorrhea, elevated FSH levels and XY karyotype, who was submitted to laparoscopic bilateral gonadectomy, after visualization of a rudimentary uterus and streak gonads.

V-14

The comparison of pelvic tuberculosis by imagıng techniques before and after treatment

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Objective: To demonstrate the modifications developed secondary to pelvic tuberculosis by the help of imaging techniques.
Method: The incidence of genital tuberculosis is reported as %4–12 in postmortem studies (1). In this study, together with the ascites image detected at vaginal and abdominal ultrasonography, the diagnosis was put by the help of USG, laparascopy, HSG, hysteroscopy and falloposcopy guided biopsies and later on the treatment was planned. By the help of images after medical treatment and evaluation of biopsies, the efficacy of treatment was confirmed.
Results: Genital tuberculosis is mostly seen in young females between 15–25 years of age, is rare in elderly. In developed countries,genital tuberculosis is mostly seen in postmenapousal women (%62) (2). Infertility is the mostly seen symptom.
The case was 34 years of age, gave birth by vaginal route in 1995, and has been using preservative for contraception from that time. The primary symptoms at admission were tiredness,fever and pelvic pain. Primary genital tuberculosis is seen rarely, and usually develops secondary to reactivation of primary infection (3).
Among investigations, no other foci such as lung was detected for tuberculosis. Direct transmission from sexual partner is reported , but transmission from intraperitoneal foci is rare (4). In investigations of her partner, there were not any tuberculosis foci detected. Due to tubercules located at the serosal surfaces of genital organs, nodularity can be detected at douglas. Rarely ascites can be detected. In vaginal touche,mild tenderness was present and there were 30–40 cc of ascites in douglas pouche.
Leucocytosis is absent in most patients, and sedimentation is usually high. In this case, the leucocyte count was 6.3 K/uL and the sedimentation rate was about 62–71 mm/hour.
Conclusion: The exact diagnosis is put by pathological investigation, and direct visualisaton of bacil in direct smear or culture (5,6,7,8,9).
In this case, no other pathologies were detected at USG, HSG,laparascopic and hysteroscopic imagings besides pertoneal tubercules,and the ascites at douglas pouche. Tuberculosis was suspected in biopsies taken from periton and lymphocytes were detected in cytological investigation. In this case ,there was complete remission of peritoneal surfaces from tuberculosis in laparascopic investigation after tuberculosis treatment was established and there was no pathology in biopsy. In falloposcopic examination, the partial absence of tubal epithelial fold was detected and at HSG and hysteroscopic investigations there was not any pathology and difference between pre-and after treatment.

V-15

Laparoscoric sacrocolpopexy vs. Prolift in treatment of genital prolapses

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Introduction: Laparoscopic sacrocolpopexy (Ls SCP) is a popular procedure in our clinic.
Methods and Results: From 1996 year we have done 224 Ls SVP in patients with genital prolapses (GP) III-IV degree. We preferred hysterectomy, colporraphy in the most cases. This type of treatment has proved to be efficient in 96% of patients, no erosions and foreign body reaction. The advantages of Ls SCP are: low risk of infection, because there is not big vaginal incision; no dispareunia, because we used physiological way of vaginal tube. The disadvantages are: long operation time (>2 hours); high risk of complications in patients with cardio-vascular problems, obesity women and women who had open surgery before.
From 2005 we have done 58 procedures by Prolift system in cases with GP IV. The advantages of Prolift are: universalism of operation, it can be done under regional anesthesia. The disadvantage is high risk of infection, because there are big size of synthetic prosthesis and big incision of the vaginal mucosa.
Discussion: We prefer Ls SVP in patients with long history of activities life (sex incl.). It should be better to use Prolift system in old patients with extra- genital pathology, obesities women and women who had open surgery before.

V-16

Different types of tension free vaginal tapes (tvt, tvt-o) in treatment of stress incontinence

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Introduction: About 45% of postmenopausal women in Russia have disorders of urination and stress urinary incontinence (SUI). More than 5 000 women with genital prolepses were operated in our clinic since 1990. Among them 47, 3% had SUI.
This study was performed to evaluate two different surgical treatments for SUI and their clinical results.
Methods: 310 patients were operated using TVT (206 patients) and TVT obt (104 cases) from 2000 to 2006 year. Age of patients is 14 to 79 year (average 49, 7). There were 43, 9% postmenopausal women. In most cases TVT/TOT and surgical treatment of genital prolapses have done in one time. There was TVT/TOT and colporraphy, VH, Manchester or colpocliesis.
There were been 24 complications, when TVT was done: bladder perforations-5(1,6%), hematoma-2(0,6%), disorders of bladder emptying-18(5,8%). There wasn't complication when TVT obt was performed.
Results: Long-term results (6 years) of surgical treatment of SUI by TVT/TVT obt technology have shown 95, 7% excellent and good results and 4, 3% of patients have minor symptoms of incontinence (de novo incl.). The negative results were not noted after TVT obt. All patients are "dry", without any disorders.
Discussion: Now TVT is considered "gold" standard of surgical treatment of SUI. But transobturatorium way (TVT obt) has some advantages: no risk of bladder perforation, no postoperative disorders of bladder emptying.